SAVE PRINT CLEAR

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

Applicant

v.

Defendant

Case No(s): _____

_____

_____

☐ **FORM TO BE KEPT CONFIDENTIAL (if box checked)**

REQUEST FOR ACCOMMODATIONS BY PERSONS WITH DISABILITIES

1. Name: _____ Telephone Number: _____
2. Address: _____
3. Person making request is: ☐ Applicant ☐ Attorney ☐ Witness ☐ Other: _____
4. Dates accommodations needed (specify): _____
5. Impairment necessitating accommodations (specify): _____

   _____
6. Type of accommodations (specify): _____

   _____
7. I request that my identity: ☐ be kept CONFIDENTIAL ☐ NOT be kept CONFIDENTIAL

Date: _____

_____ _____

(TYPE OR PRINT NAME) (SIGNATURE OF REQUESTOR)